APPEAL NO. 010065-S

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing (CCH) on remand was held on December 5, 2000. The matter had been remanded in Texas Workers' Compensation Commission Appeal No. 002237, decided November 10, 2000, because the hearing officer who had earlier considered this matter had not properly analyzed whether additional back surgery was under active consideration at the time of statutory maximum medical improvement (MMI), but had considered whether it was under active consideration when the designated doctor did a first report.

The hearing officer who considered the remand pointed to the fact that the appellant (self-insured) had denied a requested discogram that the treating doctor had repeatedly ordered before statutory MMI. Eventually, after statutory MMI was reached, a discogram was approved and showed the need for surgery, which was also approved through the second opinion process. The designated doctor's ultimate impairment rating (IR) was 16%, after a second surgery, and the hearing officer apparently gave this report presumptive weight by stating that the great weight of medical evidence supported it.

The self-insured has appealed, arguing that the designated doctor's amended reports were not done for a proper purpose and should not have been given weight. The respondent (claimant) responds that denied medical testing may be considered in determining whether the amended reports of the designated doctor were proper.

DECISION

We reverse the hearing officer's decision and render a decision that the claimant's IR is 11% in accordance with the second amendment of the designated doctor, Dr. M, which was done for a proper purpose.

The facts are set forth in the earlier Appeals Panel decision as well as both hearing officer's decisions in this matter. It was stipulated that "statutory" MMI was reached on September 1, 1997. Dr. M rendered three reports of IR in this case: 5% on October 17, 1996; 11% on February 11, 1999, following the claimant's back surgery in June 1998; and 16% on April 20, 2000, after a second surgery to remove hardware.

It took from December 6, 1996, until January 23, 1998, for a recommended discogram to be approved by the self-insured. As the attorney for the self-insured stated at this CCH:

> We were the reason that they could not get the discogram. The discogram was done. And when it was done, they were right.

In short, had the discogram been approved when ordered, the resulting surgery could have been done that much earlier. The self-insured, nevertheless, asserted that because the claimant did not expressly argue at the time that he was not having surgery because the discogram was denied (and because he had some pain relief injections after the discogram but before surgery was done), the postsurgical IR evaluation by the designated doctor was not proper. The self-insured also pointed out that the 11% amended IR done after the claimant's June 1998 back surgery was not disputed when certified in February 1999, and that the claimant did not complain of additional pain from his implanted hardware until a few months after this amendment, so that the 16% IR was clearly not done for a "proper purpose" because hardware removal surgery was not under active consideration.

In our opinion, whether surgery was under active consideration at the time of statutory MMI may appropriately be evaluated in light of whether an evaluative test has been requested and pursued, but is denied, by the carrier. A carrier should not be permitted to argue that surgery is not under active consideration when it has refused payment for performance of an essential evaluative test that would have put it under active consideration. The hearing officer did not err in equating the treating doctor's active and repeated pursuit of the discogram as active consideration of the surgical option.

We find more merit in the self-insured's argument that the 16% IR amendment was not done for a proper purpose and should be disallowed. The hearing officer explained rejection of the 11% amended IR because it was described by Dr. M as "likely inaccurate" and invalid as to range of motion (ROM) deficits (for which 0% was allowed). It is true that Dr. M expressed regret that she was required to "technically" invalidate the claimant's ROM testing although the claimant continues to have residual postsurgical problems. Dr. M recommended that "[claimant's] medical be kept open in order for him to fully avail of medical and adjunct services to correct and/or relieve his continuing post-surgical problems." However, the reports of the treating doctor that were written at this same time do not opine that hardware removal might be necessary. Although the hearing officer focuses on Dr. M's statement that ROM testing done for the 11% IR was invalid and thus may not accurately reflect the residual problems that the claimant has, the delay between this report and the ultimate April 20, 2000, amended IR is not addressed by the hearing officer.

The surgery to remove the hardware, as pointed out by the self-insured, was not "on the table" at the time the second IR evaluation was done. The opinion that the claimant "may be" a candidate for hardware removal was first noted by the treating doctor in June 1999, almost a year after his back surgery. It was not contemplated as simply a second stage of his original surgery, but occurred as a result of the development of new problems.

What is referred to as "statutory" MMI is the point of 104 weeks from the date that income benefits begin to accrue. Section 401.011(30)(B). This may occur before MMI is reached from a purely clinical standpoint. However, resolution of IR cannot be indefinitely deferred for a potential lifetime of medical treatment done in order to achieve medical MMI.

Dr. M's suggestion at the conclusion of her second amendment that the claimant's medical be "held open" is tantamount to a recommendation that the resolution of IR be indefinitely postponed.

While the second amended IR of 11% was done for a proper purpose (and could have been done sooner had testing leading to surgery not been denied), the third IR amendment was not. We, therefore, reverse the hearing officer's decision and render the decision that presumptive weight should be given to the second IR of 11%, which is not contrary to the great weight of other medical evidence insofar as fixing an IR proximate to the time of statutory MMI.

Susan M. Kelley
Appeals Judge

CONCUR:

Thomas A. Knapp
Appeals Judge

Robert W. Potts
Appeals Judge